



## BLACK-OUT AVOIDANCE PROGRAM

### STUDENT ACCEPTANCE

I hereby agree that I am a current full-time undergraduate student of Brock University. I am eligible for the Student Health Plan.

I agree that I have not opted out of the Plan, nor will I opt-out of the Plan.

I accept that in the event that the Prescription Drug Claim that I am filing is not covered either by my ineligibility or the ineligibility of the drug, I agree to reimburse Glenridge Pharmacy directly.

NAME: \_\_\_\_\_

STUDENT ID #: \_\_\_\_\_

EMAIL: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

AUTHORIZED BY: \_\_\_\_\_

(Signature)